

1 KAMALA D. HARRIS
Attorney General of California
2 KAREN B. CHAPPELLE
Supervising Deputy Attorney General
3 NANCY A. KAISER
Deputy Attorney General
4 State Bar No. 192083
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-5794
6 Facsimile: (213) 897-2804
E-mail: Nancy.Kaiser@doj.ca.gov
7 *Attorneys for Complainant*

8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013-821*

13 **MISTY RALYN FEALY**
24451 Joshua Avenue
14 Boron, CA 93516

A C C U S A T I O N

15 **Registered Nurse License No. 744471**

16 Respondent.

17
18
19 Complainant alleges:

20 **PARTIES**

21 1. Louise R. Bailey, M.Ed., R.N. (Complainant) brings this Accusation solely in her
22 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
23 Consumer Affairs.

24 2. On or about February 9, 2009, the Board of Registered Nursing issued Registered
25 Nurse License Number 744471 to Misty Ralyn Fealy (Respondent). The Registered Nurse
26 License was in full force and effect at all times relevant to the charges brought herein and will
27 expire on March 31, 2014, unless renewed.

28 ///

1

2

5

6

10

14

15

17

18

19

25

26

9. Fluoxetine HCL (Prozac) is a selective serotonin reuptake inhibitor and is categorized as a dangerous drug pursuant to section 4022 of the Code. It is used to treat depression.

10. Losartan (Cozaar) is an angiotensin II receptor antagonist. It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022 and is used to treat high blood pressure (hypertension).

11. Divalproex TBEC (Depakote) is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat seizure disorders.

12. Levetiracetam (Keppra) is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat seizure disorders.

FACTUAL SUMMARY

13. On or about May 22, 2010, patient GL, an 83-year-old female, was admitted to the intensive care unit of Antelope Valley Hospital, Lancaster, California (AVH), with a diagnosis of chronic obstructive pulmonary disease, congestive heart failure, clostridium difficile colitis, pneumonia and renal failure. Patient GL was kept in the intensive care unit for three days. On or about May 25, 2010, patient GL was transferred to the telemetry unit because her condition had improved.

14. On May 25, 2010, AVH's pharmacy mistakenly inputted medications that had not been ordered into patient GL's Medication Administration Record (MAR), specifically, Methadone, Fluoxetine (Prozac), Losartan (Cozaar), Divalproex TBEC (Depakote) and Levetiracetam (Keppra). MARs are issued by the pharmacy in the evening to be used by the hospital's nurses to care for their patients the next day.

15. It is the policy of the AVH that the night shift nurse assigned to a patient is required to verify the new Medication Administration Record (MAR) for that patient to prevent medication errors, as follows:

a. If a new drug is listed, the nurse reviews the physician order to confirm if the order was written for the medication.

b. If a drug is stopped, the nurse reviews the physician order confirming that a stop order was written for the medication.

1 c. If an order cannot be found in the patient's chart, the nurse calls the pharmacy
2 to verify and locate the order. If an order cannot be found at the pharmacy, the nurse calls the
3 physician to verify the medication order.

4 d. After steps 1, 2 and 3 are completed, the nurse initials on the left upper side of
5 the form, in a box called MAR verified.

6 16. On May 25, 2010, while on duty as a registered nurse in AVH's telemetry unit during
7 the night shift (1900 to 0700 hours), Respondent was assigned to care for patient GL, but failed to
8 verify patient GL's MAR.

9 17. In the morning of May 26, 2010, the day nurse administered to patient GL the
10 medications that were erroneously listed on the MAR that were left uncorrected/unverified by
11 Respondent, except the day nurse did not administer the Methadone. After the wrong
12 medications were administered, patient GL's condition deteriorated, and she was transferred back
13 to the ICU, where she was declared brain dead and died on May 28, 2010, at 1300.

14 **CAUSE FOR DISCIPLINE**

15 **(Unprofessional Conduct)**

16 18. Respondent is subject to disciplinary action under section 2761, subdivision (a), in
17 that while on duty as a registered nurse at AVH, Respondent committed unprofessional conduct
18 by failing to verify patient GL's Medication Administration Record in violation of hospital
19 policy. Complainant refers to and by this reference incorporates the allegations set forth above in
20 paragraphs 13 through 17, as though set forth fully.

21 **PRAYER**

22 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
23 and that following the hearing, the Board of Registered Nursing issue a decision:

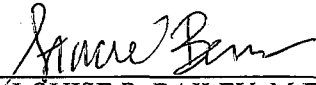
24 1. Revoking or suspending Registered Nurse License Number 744471, issued to Misty
25 Ralyn Fealy;

26 2. Ordering Misty Ralyn Fealy to pay the Board's the reasonable costs of the
27 investigation and enforcement of this case, pursuant to Business and Professions Code section
28 125.3; and,

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

3. Taking such other and further action as deemed necessary and proper.

DATED: March 26, 2013


for LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
State of California
Complainant

LA2012507953
51252171_2.doc